

The Maternal Postnatal Disorders – Assessment and Intervention from a Maternological Perspective

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Abstract

Introduction: *The postpartum emotional disturbances should be seen as a public health problem, as statistics show that at least 20% of mothers go through such distress, and there is more and more scientific evidence that these not only affect the woman’s condition but also the development of the child on the long run.*

Objectives: *This paper aims to present the maternological perspective on human development and mother-child relationship, to illustrate, by case studies, the psychological evaluation and intervention, as well as to highlight the need for a specific approach of the mother-child dyad.*

Methods: *The method used is a qualitative one, the paper presenting case studies. We used the maternological interdisciplinary method (psychologist-physician) of observation and analysis of the nursing moment (video clinic), the interview and standardized questionnaires (e.g. Beck Depression Inventory). The therapeutic intervention was carried out in individual and group psychotherapy sessions.*

Results: *In the analyzed cases, improvements in children’s symptoms and maternal sensitivity were observed; mothers expressed positive changes at the levels of mood, interaction and perception of the child. By observing the baby’s behavior and symptoms, as well as his interactions with the mother, we can have access to a better understanding of maternal suffering. By providing accompaniment/ psychological support and empathic listening to the mother we help her rediscover past injuries and wounds, foster emotional unblocking, and empower connection, increasing her being present for the baby.*

Conclusions: *Ensuring emotional support for mothers, as quickly and appropriately as possible, within the first few months of birth, proves its beneficial effect in real time by improving the child’s health and balance in the relationship between the two. We believe that the observations made so far can set the basis for more extensive studies that emphasize the quest for a specific way of intervention in postnatal psychotherapy, in accordance with the perinatal needs of the mother and the baby, an intervention with focus on mother and child together.*

Keywords: *postpartum disorder, psychological birth, support group, psychodrama*

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I. Introduction

Emotional disorders in the postpartum period should be tackled as a public health issue, as statistics indicate that about 20% of mothers are going through such difficulties. And this percentage refers to the cases that are serious enough to be psychiatrically diagnosed and are eventually receiving treatment. Maternal care often occurs too late, when the symptoms are already set in and chronic, which leads to a psychiatric approach of the treatment. Unfortunately, it does not address the maternal distress itself, but only its symptoms, and leaves it to evolve in secret, with subsequent repercussions on the psychosomatic development of the child. And there is more and more scientific evidence that maternal distress affects not only the woman's condition but also the long-term development and health of the child.

Maternology is a recent medical science, born in France, at a clinic in Versailles, that has developed its theory and therapy over the past 30 years, starting from the study of mothers and children experiencing distress after birth and first year of life. The founder of maternology was Dr. Jean-Marie Delassus, a child-psychiatrist and psychoanalyst.

Maternology is defined as a "therapeutic approach centered on the mental dimension of maternity, which addresses the difficulties of the mother-child relationship" (Le Grand Robert du Langue Français, 2012) and which aims at overcoming the bottlenecks to ensure the harmonious development of the child and the mental health of the mother.

Specific concepts proposed by maternology

a) Psychological maternity

Many of the women who give birth admit that they suffer from the fact that the maternal sense or 'instinct' does not occur naturally. This proves that maternity is not instinctive. Mother's milk does not always occur spontaneously, on its own, with the birth of the child. Human maternity does not have a very precise definition, it is explained by its somatic manifestations related to pregnancy and childbirth (Delassus, 2000). However, maternity is a specific psychic structure, which, in order to be acquired, requires some stages of development throughout life. The woman is not necessarily a mother, she can become a mother if she goes through a certain psychic evolution and then wants to become a mother.

b) Psychological birth

Physical birth is only the exit of the child from their mother's body, while the psychological birth is the coming into life of their psyche, that will develop from

the moment of their birth and will continue to do so until the age of seven. It is a continuous development. "Psychology develops according to how parents respond to the child's expectations" (Delassus, 2015). At the time of childbirth, the baby expects his pre-life to continue (the prenatal totality). If they do not immediately meet their mother and do not recognize the prenatal world in her presence, if they do not have a sufficient maternal relationship, their development may be interrupted or threatened, resulting in "birth disorders".

The mother has to connect the prenatal totality with the postnatal world, thus assuring her child's birth. The mother is the one who provides, through her psyche/self, the affective, symbolic presence, the continuation of the vital totality and gives the child the desire to be psychologically born, to firstly open to her and then to the world. Therefore, the mother is also born in her maternal role when she can unfold something from the origin world. She must have kept inside something of her prenatal totality in order to transfer it to the child. Initially, the mother transforms the world for the child, "displays it according to a state and language comprehensible for the child" so that they can recognize and accept it.

The psychological birth "takes place in and through the mother's eyes" (Delassus, 2015). By first visual contact after birth, the child moves from the intrauterine world to the postnatal world. The experience of meeting the eyes is crucial for the child, but also for the parent. Therefore, it is the gaze that determines. The mother who experiences herself being seen by the child is invested in her role. For the child, the experience of contact with their mother provides them with neurophysiological continuity, gives brain the opportunity to recreate the unit after the traumatic interruption resulting from the process of birth. When visual contact is established between the mother and the child, the cycle of the giving is established and the mother can transfer the lost totality to the child.

How can we know that between a mother and her child a cycle of giving has been created? What does the giving really mean? Giving is a state of exaltation experienced by the mother, a special state which feels like tranquility. It is not a noisy manifestation, but a state of peace, a quiet enjoyment of gentleness – characterized by Bion as a "maternal reverie". Giving is the mechanism of updating the prenatal totality, as the child is experiencing libido, in sensations, in physical contact with the mother. The gift of prenatal totality corresponds to the phenomenon called by Winnicott the "primary maternal preoccupation", that "temporary maternal madness fostering the child to find the

continuity of its existence” and the primary narcissism transmitted by the mother (Lebovici), which “will allow the child’s ego to develop and adhere to life” (Solis-Ponton, 2017). At the base of the giving cycle lie the cycles of identification between the mother and the baby, “a phenomenon of double reflection: according to which constant reverberation leads to the child’s psyche, at the same time that the woman becomes a mother, the mother of her child” (Solis-Ponton, 2017) and we shall further see that not only the observation of the mother’s condition but also of the interactions at the moment of the feeding and the manifestations of the baby can indicate whether the transfer of the totality between the mother and the child has been soundly installed.

Maternology is thus defined as a mental obstetric, because it aims at facilitating the installation of the cycle of giving between the mother and the child, the transfer of the totality, and the assurance of the psychological birth.

c) Maternogenesis

The genesis of psychological maternity is organized in four stages (corresponding to the four original phantasms revealed by psychoanalysis): creation of the originary (the formal unconscious – the experience of the first 2 years of life), breaking of the syncretism/detachment from the mother (Matricide), self-attribution of the maternal, validation from the father.

The originary is the prenatal period in which the biological experience of the totality, lived in contact with the mother, with the parents, is transformed into elements of the psyche. It is the experience of the first two years of life, which becomes the formal unconscious of the child. It is followed by the stage in which the love for autonomy is great and the child seeks to detach from the mother, this being known as the symbolic matricide. This is a critical stage of psychogenesis and corresponds to the child’s opposition phase. The will stems from the child, who is eager for autonomy, as the mother, who begins to set boundaries, no longer corresponds to the one they knew as a baby. Then the little girl assigns herself the maternal, assumes her ability to be a mother, and recognizes her gender appurtenance (“I may be like my mother”). Following this stage of development, the girl expects that her father recognizes her maternal ability. To receive validation from the father implies that the father is affectionate, responds positively to the demands of the girl and appreciates her, admiring her in her femininity. The father’s response empowers the girl to become a mother.

By going through these stages of psychological development the former girl, now grown up, has

developed her ability to become a mother. The maternal distresses (transfer deficits or transferoses) usually occur when an obstacle arises in either of these developmental stages: there is an impossibility to constitute the stage or something blocks it.

d) Maternal suffering

Being a parent implies reliving the original life, recognizing yourself in your child, and experiencing this in a state of wellbeing. Suffering appears when mothers expect to love and care for the child spontaneously, naturally, and this does not happen. When the mother does not find herself in the baby, a distress appears which can lead to birth related disorders, maltreatment or abandonment. The maternal disorder is a natural, normal human phenomenon, because maternity is neither automatic, nor instinctive. Mothers are not bad or distorted, but they feel powerless, scared, in difficulty. Therefore, the state of maternal distress does not require correction, but adequate care for the mother to mobilize the inner maternal drive.

The spirit of care in maternology refers to the concern not to stigmatize, but to make it better, so that psychological maternity to appear and the psychological birth to exist. Specialists need to show openness to the mother’s real problem, prudence and restraint against mother’s behavior and states which do not meet cultural norms, because there is no universally acceptable manifestation of motherhood. It can be expressed in varied and subtle forms.

The method in maternology and specific therapeutic approaches

As the founder of maternology said: “Motherhood is a vast world. Its analysis and exploration do not end” (Delassus, 2015). It is difficult to study the depth and diversity of maternity and its disorders in a quantitative or experimental way. What we intend to present in this paper are the ideas of a complex approach that has proven its effectiveness, and whose principles and methods we try to integrate into the real context of support programs that we offer our clients in private practice. And we highlight as well the need for this area, of perinatal psychology and maternal mental health, to develop through practice and scientific studies.

Maternology has proved that a troubled mother needs a support group to awake in her what her child has not been able to trigger – the transfer of totality. A group is needed because it is more difficult for an individual to cope with a complex maternal distress that activates a series of reactions, affects and judgements. Witnessing a mother and infant in trouble provokes intense

emotions – one can empathize with the child and judge the mother, or may have the impulse to correct her, to give her advice, everything to perceive that the child is well taken care of.

The transfer group in maternology refers to the “team of therapists gathered around a mother who presents a suffering or maternal disorder” (Delassus, 2015). The group itself creates a therapeutic context for the mother; it is a support structure that assists the mother in distress, helping her to put into action her maternal resources that were blocked. For simpler cases, requiring brief interventions, it may be enough to ensure that a group of well-intended, responsive and preoccupied persons gathers around the mother – “like an infusion with psychological oxytocin” (Delassus, 2015). But as maternal challenges are complex and different, a group of ordinary people is not enough, and a team of therapists is required to do psychological interventions to observe and understand the mother's distress, to discover the cause of her suffering. When the mother feels genuinely understood by the team, she may access the causes of her difficulty, starts to truly express herself, gives up defense mechanisms, and lets herself in their care, this further leading to the disappearance of the symptoms.

Video clinic designates the medical use of video recording tools to analyze and diagnose a mother-child relationship. Thus, it is possible to watch and replay, in slow motion, the interactions between the mother and the newborn at the moment of breastfeeding, in order to be studied by the therapeutic team (Delassus, 2015). By watching the recordings in slow motion, the team can ventilate their own emotions experienced facing the maternal distress, may better understand what is happening in the dyad, discuss and identify the cause of their sufferings, and gain a more objective experience.

Dianalysis is the characteristic therapeutic modality in which the group takes on the mother's projections, with potential to affect the child, and retrieves them detoxified and understood. Similar with the role of the nurturing mother in relation to the child (as described by Bion), the therapeutic team filters and cleanses, like in a dialysis, contents from the mother, and returns them back in a nourishing way, symbolically mothering her, and thus facilitating a healthy transfer between the mother and her child.

Accompanying the breastfeeding – if therapy (dianalysis) reduces what is toxic in the mother's emotions and painful feelings, accompanying breastfeeding has the role of supporting what is good,

facilitating the onset of the giving cycle. The mother is not replaced, no technical advice, no psycho-education, no good feeding practices are provided – there is only emotional support the mother receives throughout the process. We believe that the idea of “holding space” can adequately describe the accompaniment in breastfeeding: physically being seated next to the mother feeding her baby, being together with her, showing interest to them, without words, being emotionally available: “ensuring a simple, cautious, respectful presence, being aware of the importance of what is happening” (Delassus, 2015). These for the reasons that breastfeeding is not just a physiological feeding, but, by excellence, a psychological situation. Delassus recommends that breastfeeding accompaniment happen at least once a day, every day, so that the mother feels not only treated, but also supported, unabandoned.

II. Objectives

This paper aims to briefly present the maternological perspective on human development and the mother-child relationship, as well as to illustrate, by the use of two case studies, the assessment of maternal distress, and the possibilities for psychological intervention. We also wish to emphasize the need for a specific therapeutic approach of the mother-baby dyad.

III. Methods

What we further intend to present in this paper are our attempts to use the maternology oriented intervention and to integrate the specific methods to support the cases encountered in clinical practice. The participants were 7 women aged from 28 to 40, together with their children with ages ranging from 1 to 7 months old. We selected 2 cases to be presented. As tools we used the maternological diagnosis, an interdisciplinary method (applied by the psychologist-physician dyad): systematic observation and analysis of the breastfeeding (video clinic), as well as the anamnestic interview.

We have also used two standardized psychological questionnaires (Beck Depression Inventory and Edinburgh Postnatal Depression Questionnaire) to complete the interview and observe their usefulness in appropriately capturing the mother's state, whose suffering may be hidden consciously, or through unconscious defense mechanisms. We also used a Parental Reporting Form for Newborns and Children younger than 1 Year – Rome IV Questionnaire for Gastrointestinal Disorders, to investigate in more detail this type of symptomatology.

Assessment of the mother-baby dyad.

Observing the moment of breastfeeding is an essential tool for establishing the diagnosis and the therapeutic approach. At this point, one can observe whether the baby is doing well or not, if she/ he is properly nourished, if she / he benefits from physiological nutrition but also from visual interactions with her/ his mother. Thus we can have proof that the baby has access to the psychological relationship with her/ his mother. "At this point we can see how the shift from biological satisfaction to the discovery of psychological bonding is done" (Delassus, 2000).

The video-clinical observation makes it possible to see what cannot be directly perceived, it allows a glance into the unconscious, the psychological phenomena that manifest too fast to be perceived with the naked eye. Thus, the "unconscious of maternity" is observed (Delassus, 2015). In the proper breastfeeding, in which the baby feeds well, three phases have been observed: 1) absorption (satisfaction of the physiological need); 2) the dialogue/ visual contact with the mother (emotional feeding with "psychological milk", "breastfeeding connected to the mother's face"); 3) reverie and openness to the world. By capturing the moment of feeding we search to identify these three phases and their characteristics, based on an observation scale entitled Echobal (Echelle d'Observation de l'Allaitement, Boureau-Louvet, 2000).

The therapeutic interventions were carried out on the basis of availability and participation of the mothers in individual psychotherapy sessions and/ or group interventions. However, we have also noticed the benefits and therapeutic effects of psychological and/ or medical evaluation sessions when they are conducted in maternological spirit – an emotional containing, non-judgmental, non-intrusive and non-corrective manner.

- **Counselling/ parent-child psychotherapy, and/ or individual psychotherapy** were developed in some of the cases, with variable frequency – one weekly session or bi-monthly sessions, which we consider insufficient to support the mother and their situation if we consider that the child's symptoms affect his/ her development and the quality of family life.
- **Group interventions** – sought to create, to a certain extent, the effects of the transfer group that Delassus mentioned, paying careful attention to and understanding the mother's underlying problem, in order to filter her projections, intense negative emotions, which she generally directed towards the child.

Accompanying breastfeeding has also functioned as a therapeutic intervention in groups, thus benefiting from nurturing relationships established between participating mothers, and between therapists and mothers.

The baby massage group – one of the alternatives of group intervention, with great prevention value, is the baby massage group. Initially set up as a psycho-educational group for new parents, this group gave us the opportunity to observe the positive aspects that arose in the mother-child relationship in the accompanying breastfeeding situation and the need to process the birth experience to ensure the emotional balance of the two.

The group was designed for mother-baby dyads (the father was included if he wanted to participate), and ensured a physically and emotionally supportive environment, in which we supported the mother's psychological birth, we encouraged and strengthened self-confidence in the new role. It took place in 4 hourly sessions, once a week. Generally, the groups were carried out with a minimum of 3 and a maximum of 5 mother-baby dyads. The group was closed, as participants remained the same persons until the end.

The general objective implies to provide concrete information to parents on how to perform massage care, its benefits, practicing this group massage with the actual child alongside other parents, developing their sensitivity to the child's signals, improving their communication.

The physical environment in which the sessions take place is designed to create physical safety and comfort, emotional containment and openness. It is a warm environment, like a nest, where mothers can relax and create for their children as well the feeling of a nest. Initially, they even build a physical nest for babies to feel protected. Working on nappies/ mats, pillows, the mother has to look for a comfortable position, the baby being held either in the arms or on the mother's body during the massage. Attention paid to the needs of the mother, as well as to those of the child is important and awareness is facilitated on all sensory ways, by stimulating the senses – using soothing and joyful music, pleasant colors, warm tea, the smell of fresh fruits and vegetable massage oils, gentle touch and nourishment.

To facilitate the children's relaxation, the mothers are guided to become aware firstly of their own body and state of mind. Thus, the massage begins with a brief moment of mindfulness/ relaxation for the mother, by paying attention to breathing, relieving stress

from the body, releasing thoughts and intense emotions, to be emotionally available to the baby.

An important aspect lies in respect – the attitude towards the child as a human being, as a person, not as passive object. The massage should be done only when the child can enjoy it and actively participate. Mothers learn to ask for the child's permission verbally and/ or nonverbally (it is the intention that counts and that is perceived by the child). They also learn to observe his/ her reaction and to understand the meaning of the response, to act according to the child's needs. The parent respects the child's state and needs – so she does not do the massage if the baby sleeps, feels hungry or tired or, for various reasons, simply does not want the massage.

The behavior of the facilitator/ therapist is guided by the maternological principles concerning the provision of care – non-action, non-judgment, mothering the mother, emotional accompaniment to breastfeeding. The therapist always holds a baby doll in his/ her arms, acting as having a real baby. Thus, without giving specific information about properly holding the baby, the message is transmitted implicitly to the mothers. They can consciously and/ or unconsciously model the facilitator's body attitude. Thus, the mother's gestures are not corrected, there is no direct interference with her abilities, but she is supported in discovering her own way of being a good enough, containing mother. The therapist does not touch the babies to give technical advice. All massage maneuvers are performed by the therapist on the baby-doll. Only at the request of the mother she can be helped with the baby when it is needed – if she goes to the toilet, wants to change or feed him/ her, or if she wants to take care of herself.

We initially started as a massage course, as proposed by the International Association of Infant Massage, but we preferred to turn it into a massage group because the essence is no longer a psychoeducational approach for new mothers, but a non-directive support and guidance towards discovering one's actual child, her emotional relationship with him/ her and thus her own maternity.

The mothers group had an essential role, that of creating a supportive atmosphere, unconditional acceptance, the liaison with other participants, experiencing emotions together, irrespective whether these are painful or pleasant and energizing. An atmosphere of containment was created; the group was mothering and taking care of each participant, giving her the necessary emotional support and the confidence that she could overcome difficulties. By observing other

parents in relation to their children, being aware that they were not the only ones experiencing certain difficulties, meeting other children with their traits, might give the mother the opportunity to feel self-confidence and security. She was not the only one in distress, other parents might also feel helpless, and other children could be difficult at times. They learnt from each other, shared personal experiences and deep emotions, and physically and emotionally relied on their relationship with their babies.

Within the massage group, one of the most effective maternal interventions was accompanying breastfeeding, and the visible effect that occurred frequently was the emergence of authentic connection moments: the rise of the giving cycle and the transfer, the encounter between the mother and her baby through a gaze.

The mother-baby support group – was developed in 8 bimonthly sessions, by the psychotherapist-physician team with 3 mother-baby couples, as a closed group. Similarly with the massage group, children were active participants.

Apart from talking therapy means, we also used experiential methods, based on psychodramatic techniques, aimed at facilitating emotional expression, connecting with the child, increasing mother's sensitivity towards her baby, exploring life history and connecting with one's own inner child.

Within the support group, we wished to create a framework which allowed new mothers and their infants freely express themselves, upon their needs – to talk about their present difficulties, which they usually hid, as they felt ashamed and guilty, to become aware of and express their unpleasant or painful emotions, to discover their resources in the maternal role, as in others, and to explore, to some extent, aspects of their past: the experience of birth, family relationships, their relationship with their mother and father, significant moments from the childhood (e.g. conflicts/ losses/ separations.), maternity myths and themes from their origin families.

Since the beginning, we have created group rules to establish the safety framework. Besides those proposed in the first session by participating mothers, we set new rules of confidentiality, and paying attention to individual needs. The duration of each session was of 90 structured minutes, and approximately 30 unstructured minutes, at the end, according to their needs – in which mothers were preparing to leave, fed children, changed their diapers and discussed or asked for information. The children were active participants,

not just companions of the mothers, so the activities were carried out by taking into account their needs and condition. Mothering the mothers, as a permanent caregiving attitude, was present during each session – with attention to their needs and comfort, with support in caring for the child, permanent encouragement and listening to participants.

Each session implied three moments: an initial phase – updating and connecting to the group; a theme of exploration; and an ending stage. Being an emotional support group, we followed the needs of the participants without having a rigid activity structure, but we also proposed certain directions for exploration. Sometimes, in the end, we answered questions and provided brief information (of psychological or medical nature), about the development of the child and the mother, about the “normality” of their state of distress. For example, in *session 1*, we began with the presentation of each participant and their baby. We further proceeded to setting up group rules concerning safety – “What do we need to make happen in the group? What do we not want to happen in the group?”. They discussed and set a list of rules: “No to criticism among us; No to unsolicited advice; Ask for help when we need; Listen to whoever speaks; Let us be open-hearted”. Then, everyone shared how they felt as mothers, how their life was at the moment. The participants formulated messages addressed directly to the baby regarding their expectations during pregnancy (“While pregnant I imagined that you would be... that I would be... We expected that after your birth...”) and what she then enjoyed as a mother. Conclusion – sharing how they felt throughout the meeting and a thought for the week that would follow; addressing questions.

During the sessions, we used the double and mirror techniques a lot, as the facilitators would verbalize what they felt mothers and babies could not, while reflecting what we saw in their attitude and in the interactions with the children. We encouraged each mother to do the same with her child – to observe, be empathic, verbalize her feelings, and mirror him/ her. And we also encouraged mothers to offer each other mirroring – as a closing activity, at the end of a session, each participant would choose someone and tell her how she saw her in the group and what she liked about her as a mother.

During *session 4*, we introduced colored scarves to give a material form to feelings, by creating a map of their emotional states. Then they created a map for the baby, putting themselves in their place and verbalizing what they thought children felt. In *session 5*

we introduced musical instruments to create a musical story of their emotional state, and explored various sounds and rhythms with the babies, to express their emotions in a different manner. *Session 6* focused on body signals (physical discomfort) and the relationship with their body – in the past and now, how the body changed following being mothers; we further explored their stories from the age of 6-7 months, and their relationships with the parents.

IV. Case studies

Case 1. A “volcanic” maternity

Mrs. H., 31 years old, attended the preliminary consultation together with V., her 4-month-old daughter, and her husband. V. was a big, round-faced baby girl, with a passive expression, while her mother appeared thin, athletic, smiling, emotional and talkative; her husband kept silent and had a gentle expression. V. had a normal weight at birth, and at the time, at 4 months old, already weighed 9 kg. The mother strived to hold her in her arms. She was described as an irritable little girl who “yelled”, frequently wept and was difficult to comfort by anyone.

Their current difficulty was “her crying and screaming irritates me, she has gas and her belly hurts often”. The girl suffered from dyskinesia (had difficult defecation) and might be allergic to proteins in cow milk. During that period, many physicians were consulted and they performed various tests to detect the source of abdominal discomfort.

The mother described herself as follows: “I am a chaos in what I do, in how I feel and in my behavior towards V.”, “I have the feeling that everything I do is wrong, that I’m not a good mother”, “I cry every day, for no reason, I feel an inner pressure. It feels like I am in a prison!”.

The pregnancy story – one year before V.’s conception, her mother lost another pregnancy. Thus, V. was a much-desired baby, but the pregnancy was experienced with great fear and frequent visits to the emergency hospital for check-ups. “These pregnancies have unbalanced me, I was depressed.” At 6 weeks, as there was a risk for abortion, she stayed in bed for 2 months.

The birth story – at 37 weeks, Mrs. H. chose a physician and an independent midwife, who supported natural birth. However, at 41 weeks, the birth was induced, but there was no cervical dilation, and V. was born via caesarean section. “I had dreamt of a wonderful birth. But it was a great disappointment!”

The post-natal experience was difficult, the mother getting home exhausted after 3 days in hospital. “No bonding was created, I was disappointed, I did not feel she was mine! They put her on my chest after birth, but I did not know what to do! I was very afraid and did not sleep at all while I was in the hospital.”

The return home – “There the chaos began; we were alone with her without help. I do not remember the first few days at home! All I know is that she was constantly screaming and not sleeping. I also suffered from mastitis. At 3 weeks old, V. fell ill and both of us were hospitalized – she neither ate, nor breathed properly, I had fever.” Since then the mother had few more episodes of fever and several of mastitis.

Until she turned two months old, V. would frequently vomit. In the same period, her mother’s irritation reached a peak, getting close to violence. “I wanted to hurt her, she was crying and I wanted to hit her head against the bed, to throw her away!” At the time, Mrs. H. attended several psychotherapy sessions, in the meantime the baby being left in the care of a friend who could feed her. These free hours were like a breath of fresh air, an escape. “It was good, as if I did not have a child, and I wanted to leave her there.”

At the moment, V. sleeps at night, but sometimes she wakes up in pain, she eats and develops properly, but she would always be at the breast. The father is worried that she might suffer from something serious, her mother is worried that she might traumatize the child with her anger outbursts – “I lose my patience very easily, I’m afraid I will hurt her in the future, when she starts doing mischiefs”, “I am feeling very lonely, I cannot enjoy being with her.” The mother is afraid of herself, of the violence she feels in the presence of a child whom she perceives as an enemy, as an aggressor.

Observations: V. is an irritable baby; she suddenly starts to shout for no apparent reason. In those moments, the mother intensely blushes, on her face, chest and neck. She handles the baby in a sudden, impulsive, rigid manner. She generally finds it hard to hold the baby and when she does, the baby is facing the others, with her back against the mother. Whenever V. is distressed, her mother leaves her alone, in an armchair, and V. is soothing by herself.

Analysis of breastfeeding (sequence 1): V. only eats in a certain position, on her back, lying beside her mother, her legs up, leant against her mother. She acts reluctantly, refuses the breast and start screaming until she is helped to sit in that position. She anticipates the moment of feeding and manifests gestures of impatience and pleasure.

The milk flow is very strong, often V. stops eating because she feels like drowning and the milk sprinkles on her face. As the mother describes it, breastfeeding is “volcanic”, “the breast is exploding with milk”. The feeding problem occurred about 1 month after the birth, “when the breasts started to explode in her mouth”. Since then she had been eating somewhat superficially, she was distant, pulled from the breast to protect herself, and sometimes had regurgitation after eating.

We observed that generally V. looks towards the breast, eats greedily, impatiently. In the meanwhile, she would also briefly glance at her mother, smiles and giggles when her mother is watching her. A certain dialogue is initiated between them in the brief moments when the mother talks to her and smiles. But the dialogue is feeble and the moments difficult to predict.

We further observed ambivalence in the mother – although she often gives V. her breast, she would also consider giving up breastfeeding, feeling that V.’s sufferings might end: “sometimes I don’t know why she eats?! Because she is not hungry! I know she likes it, the breast is her love, but it hurts her. Sometimes she refuses the breast, there is something bothering her, as if she wants to feed and does not want to feed at the same time”.

The mother mentioned that V. would be best nourished when half-asleep. When awake, she would feed greedily and regurgitate. As V. is exclusively breastfed and only eats in that position, her mother does not manage to leave the house too often, and looks forward to weekends to be with her husband. But she is sad and angry towards him: “I feel we are not connected anymore. He is uninvolved, has no reaction, he cannot calm her”.

During the second consultation, Mrs. H. found the courage to reveal more of her hidden suffering and intrusive thoughts that sometimes do not give her peace (the desire to die or get rid of the child): “Yes, I thought about hurting myself – what if I died and left her on her own, without me? Getting away...”, and hurting the baby: “How would life be without her?”. She felt oppressed, life-bound with V.

From a physical point of view, the mother felt as a “ruin”, “weak” (“my whole body hurts”). She also experienced, as did the baby, abdominal discomfort (bloating, changes in the intestinal transit – constipation) and back pain. She had lost a lot of weight. She could not eat well, sometimes did not have the appetite, on other occasions she did not have time. She also kept a diet, with food restrictions to protect her daughter from

abdominal pain. Feeding was difficult for both mother and daughter. While V. gained weight, fast and well above the average for her age, her mother got thinner every day, losing her vital force.

But, since the first meeting, Mrs. H. found the courage to get out of the house with her baby; at the second session they came unaccompanied by the father, which she enjoys. She feels more capable. What is more, while in the consultation room, she began to breastfeed in the classic position (cradling), holding the baby in her arms. She had the courage to make small changes. "I was less sad and I felt like I started to fall in love with her."

History: We explored Mrs. H.'s relationship with her own mother since the first evaluation session, when she mentioned that her mother had died three years before, of liver cancer. She was angry with her mother – "she was irritable and angry, she failed to do the right thing with me, and I do the same to my child and I do not want that". She feels punished by the divine will because she rejected her mother: "I told her I would not allow her to help me with my children, and now I feel like I am paying for it".

Exploring the relationship with the mother continued throughout each group session. We appreciate that it was a suspended grieving process, the feelings and conflicts being reactivated with much intensity since the birth of her daughter. In the group sessions she revisited past moments with her mother, to express her emotions and verbalize everything that she needed: about her mother's illness and death (that she avoided to confront with, did not involve and remained with regrets and many untold things), relevant periods from the childhood (the context in which she was born; her mother's state at that moment; the birth of her brother; the relationship with her mother throughout her life; her childhood desire to get away from her sad mother). Interestingly, Mrs. H. gave her baby the name of her mother, so V. bears the name of her late grandmother, deceased 2 years before her birth.

In the **support group**, Mrs. H. participated with great joy, in touch with her need to be listened to and helped with the child, often arrived early and started talking before the other attendees' arrival. We noticed that any sign of child discomfort, would make the mother give the breast. She did not know other ways of consolation. The mother's sensitivity was reduced; she acted rather anxious and angry when baby wanted something. She was trying to keep the child quiet. The child's crying gave her great discomfort, and she entered in a state of alertness, perhaps anger, whose physiological signs we easily noticed (blushing,

psychomotor agitation). "I am like a volcano!" said the mother, and her body expressed the state – the milk gushed on the baby, the tension rose, her rage came out, she spoke a lot and intensely ("I do not want her anymore!"). Like her, the baby was impetuous in her reactions, she protected herself from what came from her mother – she was struggling, regurgitating; she would burst out, yell, bend/ curl backwards in rejection.

Responding to the nonverbal attitude, the mother tended to let the little girl sit, somehow in instability, holding her backwards, without creating a support space. It happened that the girl lost balance and fell sideways. Though seemingly constantly concerned with the baby, the mother, did not provide the necessary holding for the child, and her gestures betrayed a need for distance.

A replacement child. In the group, while talking about the fancied and desired child, Mrs. H. realized that the reality was different from her fantasy motherhood. She expected of herself to be a patient mother, different from her own mother. She also discussed the first pregnancy, lost at 6 weeks, when she felt connected to the baby. Following the loss, upon V.'s conception, she received the advice (from family and specialists) not to attach to the new child. It became obvious that the mourning was not finished, and V. was perceived as a replacement child. To foster processing the loss of her first child, we suggested talking about what she imagined about the unborn child, expressing the positive emotions experienced during pregnancy and the suffering of the loss, by giving him an identity and a name, and sending him a message. From that moment on we reformulated "the lost pregnancy" with "the loss of baby P.". She then realized that baby V. was conceived out of their need to replace the first child's loss, just 6 months after the event. It could also be understood why V. was eating for two: it seemed that she also incorporated the presence of the lost child, from whom the mother had not been separated at the time. And, at the same time, V. maintained the relationship with her lost grandmother, by bearing her name.

H.'s motherhood was volcanic, as she described it herself. She was overwhelmed by old unexpressed anger (related to her mother, losing her first child), and new distress: towards her husband (helpless himself), towards the baby (sometimes perceived as an enemy), towards herself (because she was not how she wanted to be, because she rejected her mother, because she behaved like her mother).

Breastfeeding analysis (sequence 2): Within the support group, the mother tried to breastfeed in their

favorite position, lying next to each other, but the baby displayed discomfort, refused the breast, turned on her back, looking in the other direction. The mother was smiling but in an uptight manner. The baby gazed back with scare, at times. She turned to face her mother twice, looking only at her breast, then distanced quickly and turned to the opposite side, sucking her lip.

Breastfeeding analysis (sequence 3): V. was breastfed while being held in her mother's arms. Initially the baby looked at the breast, as her mother looked at her briefly and, at times, at the other mothers. She suddenly turned to her mother, looking scared, when another child yelled. We then observed a moment of emotional dialogue, in which V raised her hand towards her mother's face, her mother kissing it; she remained with her hand in her mother's mouth, Mrs. H. pretending to playfully eat her hand. Then V. started pushing and hitting, while her mother smiled, and continued to grab her hand. V. stayed on the breast, and while eating she began to slightly feel restless, shaking her head and hitting with her hand. She responded to the sounds of the other children, feeling afraid – she raised her eyes to her mother and her mother would look back smiling, not understanding the reaction of fear. A brief moment of connection appeared, in which V seemed to smile, but her gaze was rather scared.

Breastfeeding analysis (sequence 4): We observed a face-to-face position with a certain distance, so the mother had to stretch to provide food, in which the emotional dialogue was visible but shy, the girl was following her with the eyes, her mother responding with a smile and offering fruits.

On all recordings the facial expression of the mother seemed inappropriate in relation to the baby's attitude, who tended to withdraw. It seemed that the mother did not decode her baby's emotions and expressed an exaggerated joy, while the child felt rather scared.

Case 2. Vulnerability and fear of abandonment

Mrs. T. and her daughter M. attended the baby massage group very soon after birth. Initially, the father participated too. The family context seemed to be calm, there were no serious problems. The mother felt the need to be with other mothers. Their difficulty was related to the 1-month baby, who, at a specific moment of the day would cry and be calmed down with difficulty. "When she gets upset, she gets mad and screams as much as she can", described the mother.

In one session T. told the story of M.'s birth: a mother who was eager for a natural birth, specially

prepared for the procedure, arrived at the hospital for a check-up, feeling worried. She was hospitalized and was prepared for an induced birth. Everything went on differently than she had expected and prepared for – because there were a lot of patients, T. was quickly admitted and underwent medical procedures she did not consent for. The father was excluded and would wait outside during the birth. She remained in the pre-operator for a long time alone, without support, in great physical discomfort, fearing the unknown and angry towards the medical staff who did not explain what was happening. In the end, T. herself requested the Caesarean intervention to put an end to her suffering. Her anger and frustration grew in intensity as T. chose to voluntarily ask for a procedure she had not wished for her or the baby.

As she was aware of the emotions experienced in labor (the anger, fear, helplessness and inability to intervene), the mother expressed those feelings and thoughts within the group, in front of other participants and her baby. Exploring and verbalizing the experience helped her understand the events, process the frustration and persistent rage, and offered her the opportunity to share to her husband and daughter, in the next days. Surprisingly, the baby would calm down in that timeframe and no longer weep. The accumulated tension unconsciously experienced by the mother was strongly expressed by the child, who was also crying for her suffering during the labor. An unfinished experience, the traumatic labor and childbirth, could be, by verbalization and listening, transformed into a coherent, meaningful story which would integrate after being told and retold several times. The experience was processed and integrated as M.'s birth was accepted by her mother.

Two months after, Mrs. T. requested individual psychotherapy, feeling distressed in her relationship with the baby: "I feel like I do not want to leave her with anyone else. I am too possessive, I cannot leave her, and I have not left her with anyone else until now". The baby was very active and had troubles in falling asleep, as it seemed they could not relax together.

The postpartum experience was described as difficult both during the hospitalization and at home. "I felt very vulnerable, torn apart, I could not move, I felt distracted", "I struggled to breastfeed, because my family criticized me for having my baby at my breast all day".

We noticed that M. was a very active, curious, sociable, attentive and responsive child. The body tone was increased, the posture was tensed, with an overall good motor development. She was a child who could not afford to relax.

Analysis of breastfeeding (sequence 1): We observed a chaotic absorption phase, with interruptions, as the child felt agitated. The interaction with the mother seemed unstable, there were brief moments of contact when the baby looked for the mother's gaze and met it, but it seemed she could not stay in contact with her mother, and she turned to the outside (in defensive). The mother would get her close to the breast almost, with a slightly strained posture, being careful to observe the child's face, to process details.

Analysis of breastfeeding (sequence 2): It depicted a moment of feeding at home, recorded by the father, in which we observed a clearer, quiet absorption phase, the baby being attentive, more focused to the breast, eating well. However, the relational phase was absent, passing directly into the third phase, that of opening to the world – the baby seeking visual contact with her father and then falling asleep at the breast. The mother was attentive to the child, but showed low expressivity, a slightly passive attitude, manifesting joyful reactions to the expressivity of the child, she seemed to be feeding from her child, also.

The mother's history: Exploring the relationship with her parents was relevant. When she was born her mother was very young and her father had difficulties with alcoholism. At 7 months old, following a period of intense colds – laryngitis and breathing difficulties, her mother felt very vulnerable and frustrated, a state she initially rejected not understanding the cause: would feel a great deal of sadness, the need to cry, anger, helplessness. She felt she had a knot blocking her neck and chest (like her little girl T., the symptoms in breathing).

Mrs. T.'s story revealed that when she was a 7-8-month-old baby had been left by her parents in the care of her grandmother. The feelings of abandonment came to light, the sadness of being abandoned was re-experienced and the fear of leaving her own child was very high. The suffering following her early childhood experience of separation was reactivated and relived with great intensity, possibly starting with the moment of labor (when her uterus did not dilate, when she was alone in labor) and at the time the baby reached the age at which she felt abandoned by her parents.

In addition, Mrs. T. realized that the experience of abandonment was present in her family – it also happened to her father, who, as a child, had left home to be officially adopted by a childless aunt.

Mrs. T. also spoke about her fear of not being abandoned by her little girl, who might get bored with her, being sociable and eager to meet new people. Mrs.

T's separation difficulty reappeared in relation to the little girl who was growing and opening to the world. Sleep was still a challenge, M. sleeping through the day in her mother's arms, her mother not being able to let her down.

Then there appeared another moment of separation in Mrs. T.'s history, namely, the abandonment from her grandmother, when, at 4 years old, she was taken back home by her parents who at the time were new parents of her younger brother. At her parents' home, T. could not reconnect with her very young mother, who was perceived as cold, distant, while her father was absent. For that reason, Mrs. T. would feel and still feels great anger towards her father, rejecting him for his addiction.

V. Discussions

In the above-mentioned cases, the mothers also benefited from therapeutic interventions; we noted some improvements in the symptoms of children and in the maternal sensitivity. The children's manifestations have changed even during sessions, as mothers freed themselves from intense emotions and verbalized past or present experiences. The psychomotor agitation diminished, the babies' attention and presence were getting better during the meetings. In some cases, these improvements have been maintained; others have not persisted at home, as the mothers had no emotional support.

In the first case, V. became quieter, less irritable, the abdominal discomfort diminished. However, she was administrated homeopathic treatments and food diversification was initiated, which may have helped in the food intake process. During the sessions, her mother enjoyed the socialization she had missed so much, she became more aware of the good moments with her baby when she was quiet. Most importantly, she was released from the tensions erupting from the inside (intense anger towards her mother, husband, rage towards herself, fear of her not being a good mother). As she could access the painful experiences from her childhood, she re-experienced, verbalized and re-signified her thoughts and feelings. After a while, Mrs. H. could connect to her little girl, perceive her without being disturbed by her own ghosts, without projecting her own anger and emotional violence. As the mother's inner tension had diminished, the baby started to act more calmly, and we noticed that she become more cooperative. She began to develop better motricity; she could support herself better while sitting and could accept to lie on her belly.

In the period of food diversification, after 6 months, the two participated in the baby massage group, at which point we noticed at the time of feeding a better interaction between the two: a mother more present in the emotional dialogue and a quieter little girl with an initiative in feeding, without the intensity of the relational struggle during breastfeeding. For the mother, expressing intense emotions and the awareness on the unfinished losses brought some inner peace and allowed partial contact with her little girl. However, in the child's attitude would remain a state of fear, of alertness, more clearly observable in the video analysis, and an inadequacy in the mother's reactions that still seemed unable to decode her daughter's response and manifested a state of exaggerated joy in relation to the child's reactions.

In the second case, of Mrs. T., given the details of the assessment, we have assumed that, from an emotional perspective, it was a reversed breastfeeding situation, the mother feeding from the child, finding in their relationship that symbiosis traumatically lost following early separations. This caused her to relive the intense fear of abandonment. The relationship with her father was crucial, his absence being of significant importance for the final stage in maternogenesis. Not having a present/responsive father, and having separated early from her mother, not being able to fully reconnect with them after returning home, as the rival appeared (the younger brother), T., as a little girl, got blocked in the feelings of deprivation, loneliness, the need for support, with insecure attachment. As an adult, these materialized in a difficult, unstable couple relationship, with an immense need for emotional support, and after the child's birth, in an acute fear of loss and separation. As therapeutic goals for her there can be mentioned: T. strived to grow healthily in relation with her daughter, seeking for help, being able to relax, dealing with the couple challenges, feeling secure in leaving M. in the care of someone else, without the fear of repeating the abandonment scenario of her parents and grandparents. She started to allocate time for the professional life and to invest her energy in other directions in order to relax as a mother and take care of herself.

In both cases, the therapeutic process was discontinued four months after the conclusion of the support group (which was insufficient) and was not resumed. But the team continued to keep contact with the participants and intended to monitor their condition and as well as the children's health and evolution.

The mothers participating in the support group and the baby massage group showed and expressed improvements in their emotional state, in the interaction with their babies and/ or their perception on the children. Some of them provided useful feedback:

"I was very excited that you managed to help me feel me more relaxed and confident in my relationship with him. When you took the picture of him, looking intensely in my eyes during breastfeeding, it was the first time I could maintain contact for such a long period of time and I think this happened because he could relax and received the massage well. I realized how important physical contact was for him. It was a pleasant experience that we both enjoyed" (mother of a 4 months old boy).

"I'm glad I discovered the massage as a way to connect with her; it's another kind of caress. I noticed she enjoys it, and I have great satisfaction that I can make her feel that way. I liked meeting with other mothers and that made me have less doubts" (mother of 4 months old girl).

Support groups offer the possibility of significant emotional and physical support, especially as more and more mothers live isolated from the extended family, spend most of the day alone with the child, as the partners work until late. Even physiologically, it is scientifically proven that because of the mirror neurons activating in the brain of a mother that sees other mother-child dyads, more oxytocin is secreted, a hormone that facilitates the mother's receptivity to her own child and the mobilization of the maternal drive. The group represents, to some extent, the framework that facilitates the maternal transfer and the installation of the giving cycle, so intensely experienced in deep eye-to-eye moments between the mother and child.

The psychodramatic-experiential techniques proposed within the group, such as the double, the mirror, the suspended response, the inversion of the role, the concretization of the inner world, of emotions and thoughts by the use of various objects (scarves, pillows, figurines), the creative means of expression – with musical instruments, shape and color – gave mothers the opportunity to have access to their own experiences, to become aware of them, to express and understand them. And thus they had the opportunity to manage their feelings, to accept them, to feel better in the maternal role, to recreate narratives of their past and present stories, to communicate with their children, to put themselves in their place and to perceive them more appropriately, to become more sensitive to the needs of their children.

VI. Conclusions

Maternology offers a new, interdisciplinary and deeply humanistic perspective on the development of the human being and on understanding the maternal emotional disorders, health and wellbeing of the children in the first year of life.

By observing the infant's behavior and symptoms, as well as the interaction with the mother, we can have access to understanding the maternal suffering, which is often less visible. Accompanying and assisting participating mothers, as well as ensuring empathetic listening, the presence of the therapeutic team and the transfer group help them unveil past injuries and unfinished experiences, resulting in emotional unblocking and connection with the present baby.

The psychotherapist's attitude towards the mother, as proposed in maternology is a key element in providing adequate support in the postpartum period. The mother in emotional distress after birth needs safety, flexibility, acceptance, listening, and understanding. She needs to discover in the therapist the "good mother", while being herself mothered again, emotionally nourished, to experience the giving in the therapeutic relationship so she can return to her real child.

Postpartum psychotherapy can integrate the maternological perspective to better meet the needs of mothers and to facilitate the healthy development of the baby. The mother-baby psychotherapeutic intervention requires an interdisciplinary approach (medical and

psychological), able to address them together, to understand that they are a biological unit in itself and cannot be treated separately. The intervention must be carried out in an intensive manner, to prevent the aggravation of disorders, be non-intrusive, non-judgmental of the mother and her maternal capacity, sensitive to understand the individual process of maternity development, taking into account the specificity of the mental state and the mother's needs after birth.

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